



## STATE OF ILLINOIS

Page 2

Facility Name & ID Number Maplewood Care# 0040428 Report Period Beginning: 01/01/04 Ending: 12/31/04

## III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,  
(must agree with license). Date of change in licensed beds N/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>203</u>	Skilled (SNF)	<u>203</u>	<u>74,298</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>203</u>	TOTALS	<u>203</u>	<u>74,298</u>	7

## B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>16,987</u>	<u>1,686</u>	<u>1,020</u>	<u>19,693</u>	8
9	SNF/PED					9
10	ICF	<u>39,637</u>	<u>3,935</u>	<u>26</u>	<u>43,598</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>56,624</u>	<u>5,621</u>	<u>1,046</u>	<u>63,291</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed  
bed days on line 7, column 4.) 85.19%

D. How many bed-hold days during this year were paid by Public Aid?

None (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.  
(E.g., day care, "meals on wheels", outpatient therapy)N/A

F. Does the facility maintain a daily midnight census?

YesG. Do pages 3 & 4 include expenses for services or  
investments not directly related to patient care?YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐ NO ☒

I. On what date did you start providing long term care at this location?

Date started 04/1/93

J. Was the facility purchased or leased after January 1, 1978?

YES ☒ Date 04/1/93 NO ☐

K. Was the facility certified for Medicare during the reporting year?

YES ☒ NO ☐ If YES, enter number  
of beds certified 23 and days of care provided 834Medicare Intermediary AdminaStar - Kentucky

## IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH\* ☐ CASH\* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 12/31/04 Fiscal Year: 12/31/04

\* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

## STATE OF ILLINOIS

Page 3

Facility Name & ID Number      **Maplewood Care**#      **0040428**Report Period Beginning:      **01/01/04**Ending:      **12/31/04****V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)**

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	225,718	24,493	33,912	284,123		284,123	(19,889)	264,234		1
2	Food Purchase		289,156		289,156	(31,128)	258,028	(256)	257,772		2
3	Housekeeping	194,944	21,360		216,304		216,304	644	216,948		3
4	Laundry	52,806	24,474		77,280		77,280		77,280		4
5	Heat and Other Utilities			150,067	150,067		150,067	2,147	152,214		5
6	Maintenance	60,726	24,590	87,595	172,911		172,911	(21,953)	150,958		6
7	Other (specify):*							5,071	5,071		7
8	<b>TOTAL General Services</b>	534,194	384,073	271,574	1,189,841	(31,128)	1,158,713	(34,236)	1,124,476		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			6,000	6,000		6,000		6,000		9
10	Nursing and Medical Records	1,713,887	91,647	478,754	2,284,288		2,284,288	(29,605)	2,254,683		10
10a	Therapy	103,443	3,277	14,328	121,048		121,048	(3,689)	117,359		10a
11	Activities	92,719	9,078	2,856	104,653		104,653		104,653		11
12	Social Services	166,189	211	11,916	178,316		178,316		178,316		12
13	Nurse Aide Training										13
14	Program Transportation										14
15	Other (specify):*							4,259	4,259		15
16	<b>TOTAL Health Care and Programs</b>	2,076,238	104,213	513,854	2,694,305		2,694,305	(29,035)	2,665,270		16
	<b>C. General Administration</b>										
17	Administrative	57,416		75,552	132,968		132,968	(6,275)	126,693		17
18	Directors Fees										18
19	Professional Services			170,399	170,399	(2,625)	167,774	(127,413)	40,361		19
20	Dues, Fees, Subscriptions & Promotions			58,226	58,226		58,226	(22,315)	35,911		20
21	Clerical & General Office Expenses	181,799	24,212	207,386	413,397		413,397	(123,993)	289,404		21
22	Employee Benefits & Payroll Taxes			336,698	336,698	31,128	367,826	(537)	367,289		22
23	Inservice Training & Education										23
24	Travel and Seminar			4,503	4,503		4,503	445	4,948		24
25	Other Admin. Staff Transportation			5,964	5,964		5,964	2,541	8,505		25
26	Insurance-Prop.Liab.Malpractice			176,065	176,065		176,065	1,031	177,096		26
27	Other (specify):*							20,367	20,367		27
28	<b>TOTAL General Administration</b>	239,215	24,212	1,034,793	1,298,220	28,503	1,326,723	(256,149)	1,070,574		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	2,849,647	512,498	1,820,221	5,182,366	(2,625)	5,179,741	(319,420)	4,860,321		29

\* Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Maplewood Care

#0040428

Report Period Beginning:

01/01/04

Ending:

12/31/04

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			76,646	76,646		76,646	(22,892)	53,754			30
31	Amortization of Pre-Op. & Org.							16,587	16,587			31
32	Interest			124,336	124,336		124,336	517,199	641,535			32
33	Real Estate Taxes			85,960	85,960	2,625	88,585	17,766	106,351			33
34	Rent-Facility & Grounds			516,000	516,000		516,000	(516,000)				34
35	Rent-Equipment & Vehicles			9,018	9,018		9,018	3,624	12,642			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			811,960	811,960	2,625	814,585	16,284	830,869			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		48,258	33,740	81,998		81,998		81,998			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			111,448	111,448		111,448		111,448			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>		48,258	145,188	193,446		193,446		193,446			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	2,849,647	560,756	2,777,369	6,187,772		6,187,772	(303,136)	5,884,636			45

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number Maplewood Care

# 0040428

Report Period Beginning: 01/01/04

Ending: 12/31/04

## VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(43,312)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(256)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(660)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(170,190)	21		24
25	Fund Raising, Advertising and Promotional	(6,853)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(11,874)	20		28
29	Other-Attach Schedule	(38,346)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (271,490)		\$	30

OHF USE ONLY						
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
	Amortization of Organization &			
33	Pre-Operating Expense			33
	Adjustments for Related Organization			
34	Costs (Schedule VII)	(31,646)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (31,646)		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (303,136)		37

\*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

SEE ACCOUNTANTS' COMPILATION REPORT

NON-ALLOWABLE EXPENSES		Amount	Reference
1	IL CPEL Dues	5	20
2	Collection Fees	(183)	20
3	Theft Loss	(2,000)	23
4	Legal Fees (Prior Period)	(2,110)	19
5	Capitalized R&M	(7,902)	40
6	Collection Fees	(111)	23
7	Legal Fees (Non-allowable)	(22,883)	19
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101	Total	(28,346)	101

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number Maplewood Care# 0040428

Report Period Beginning:

01/01/04

Ending:

12/31/04**SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I**

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>A. General Services</b>													
1	Dietary					(14,729)	(5,160)						(19,889)	1
2	Food Purchase	(256)											(256)	2
3	Housekeeping			644									644	3
4	Laundry													4
5	Heat and Other Utilities			844	1,303								2,147	5
6	Maintenance	(7,902)		614	(12,346)		(2,319)						(21,953)	6
7	Other (specify):*				884	1,254	2,933						5,071	7
8	<b>TOTAL General Services</b>	<b>(8,158)</b>		<b>2,102</b>	<b>(10,159)</b>	<b>(13,475)</b>	<b>(4,546)</b>						<b>(34,236)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director													9
10	Nursing and Medical Records				(23,605)				(6,000)				(29,605)	10
10a	Therapy						(3,689)						(3,689)	10a
11	Activities													11
12	Social Services													12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*				3,143		1,116						4,259	15
16	<b>TOTAL Health Care and Programs</b>				<b>(20,462)</b>		<b>(2,573)</b>		<b>(6,000)</b>				<b>(29,035)</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative			16,549	(62,351)	43,847	(4,320)						(6,275)	17
18	Directors Fees													18
19	Professional Services	(25,001)		(99,043)	302	12,769	(16,440)						(127,413)	19
20	Fees, Subscriptions & Promotions	(22,710)		203	192								(22,315)	20
21	Clerical & General Office Expenses	(172,309)		57,091	(8,775)								(123,993)	21
22	Employee Benefits & Payroll Taxes							(537)					(537)	22
23	Inservice Training & Education													23
24	Travel and Seminar			162	283								445	24
25	Other Admin. Staff Transportation			556	1,985								2,541	25
26	Insurance-Prop.Liab.Malpractice			403	628								1,031	26
27	Other (specify):*			9,782	3,704	6,881							20,367	27
28	<b>TOTAL General Administration</b>	<b>(220,020)</b>		<b>(14,297)</b>	<b>(64,032)</b>	<b>63,497</b>	<b>(20,760)</b>	<b>(537)</b>					<b>(256,149)</b>	<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(228,179)</b>		<b>(12,195)</b>	<b>(94,653)</b>	<b>50,022</b>	<b>(27,879)</b>	<b>(537)</b>	<b>(6,000)</b>				<b>(319,420)</b>	<b>29</b>

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number Maplewood Care# 0040428

Report Period Beginning:

01/01/04

Ending:

12/31/04

## SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>D. Ownership</b>													
30	Depreciation	(43,312)	15,921	1,994	2,505								(22,892)	30
31	Amortization of Pre-Op. & Org.		16,587										16,587	31
32	Interest		516,000	361	838								517,199	32
33	Real Estate Taxes		11,844	2,173	3,749								17,766	33
34	Rent-Facility & Grounds		(516,000)										(516,000)	34
35	Rent-Equipment & Vehicles			2,095	1,529								3,624	35
36	Other (specify):*													36
37	<b>TOTAL Ownership</b>	(43,312)	44,352	6,623	8,621								16,284	37
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	<b>TOTAL Special Cost Centers</b>													44
	<b>GRAND TOTAL COST</b>													
45	(sum of lines 29, 37 & 44)	(271,490)	44,352	(5,572)	(86,032)	50,022	(27,879)	(537)	(6,000)				(303,136)	45



Facility Name & ID Number Maplewood Care# 0040428

Report Period Beginning:

01/01/04Ending: 12/31/04

## VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached		See Attached		See Attached		
				Maplewood-Jane, LLC		Building Co

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34 Rental Income	\$ 516,000	Maplewood-Jane, LLC	100.00%	\$	\$ (516,000)	1
2	V	33 Real Estate Tax Income	85,960	Maplewood-Jane, LLC	100.00%		(85,960)	2
3	V	31 Amortization		Maplewood-Jane, LLC	100.00%	16,587	16,587	3
4	V	30 Depreciation		Maplewood-Jane, LLC	100.00%	15,921	15,921	4
5	V	32 Interest Expense		Maplewood-Jane, LLC	100.00%	516,000	516,000	5
6	V	33 Real Estate Tax Expense		Maplewood-Jane, LLC	100.00%	97,804	97,804	6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 601,960			\$ 646,312	\$ * 44,352	14

\* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Maplewood Care# 0040428Report Period Beginning: 01/01/04Ending: 12/31/04

## VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	3 HOUSEKEEPING	\$	PREFERRED BOOKKEEPING	100.00%	\$ 644	\$ 644
16	V	5 UTILITIES		PREFERRED BOOKKEEPING	100.00%	844	844
17	V	6 REPAIRS AND MAINT.		PREFERRED BOOKKEEPING	100.00%	614	614
18	V	17 ADMIN. FINANCIAL SAL.		PREFERRED BOOKKEEPING	100.00%	16,549	16,549
19	V	19 PROFESSIONAL FEES		PREFERRED BOOKKEEPING	100.00%	1,337	1,337
20	V	20 DUES,SUBSCRIPTIONS		PREFERRED BOOKKEEPING	100.00%	203	203
21	V	21 CLERICAL		PREFERRED BOOKKEEPING	100.00%	57,091	57,091
22	V	24 SEMINARS		PREFERRED BOOKKEEPING	100.00%	162	162
23	V	25 ADMIN. STAFF TRAVEL		PREFERRED BOOKKEEPING	100.00%	556	556
24	V	26 INSURANCE		PREFERRED BOOKKEEPING	100.00%	403	403
25	V	27 EMPLOYEE BENEFITS		PREFERRED BOOKKEEPING	100.00%	9,782	9,782
26	V	30 DEPRECIATION		PREFERRED BOOKKEEPING	100.00%	1,994	1,994
27	V	32 INTEREST		PREFERRED BOOKKEEPING	100.00%	361	361
28	V	33 REAL ESTATE TAXES		PREFERRED BOOKKEEPING	100.00%	2,173	2,173
29	V	35 EQUIPMENT RENTAL		PREFERRED BOOKKEEPING	100.00%	2,095	2,095
30	V						
31	V						
32	V	19 ACCOUNT./BOOKKEEPING	100,380	PREFERRED BOOKKEEPING	100.00%		(100,380)
33	V	19 COMPUTER	4,872	PREFERRED BOOKKEEPING	100.00%	4,872	
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 105,252			\$ 99,680	\$ * (5,572)

\* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number **Maplewood Care**# **0040428**Report Period Beginning: **01/01/04**Ending: **12/31/04**

## VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	5 UTILITIES	\$	S.I.R. MANAGEMENT, INC.	100.00%	\$ 1,303	\$ 1,303	15
16	V	6 REPAIRS AND MAINT.	18,276	S.I.R. MANAGEMENT, INC.	100.00%	5,930	(12,346)	16
17	V	7 EMP. BEN.-GEN. SERV.		S.I.R. MANAGEMENT, INC.	100.00%	884	884	17
18	V	10 NURSING	40,200	S.I.R. MANAGEMENT, INC.	100.00%	16,595	(23,605)	18
19	V	15 EMP. BEN.-H.C.		S.I.R. MANAGEMENT, INC.	100.00%	3,143	3,143	19
20	V	17 ADMINISTRATIVE	71,232	S.I.R. MANAGEMENT, INC.	100.00%	8,881	(62,351)	20
21	V	19 PROFESSIONAL FEES		S.I.R. MANAGEMENT, INC.	100.00%	302	302	21
22	V	20 FEES,SUBSCRIPTIONS		S.I.R. MANAGEMENT, INC.	100.00%	192	192	22
23	V	21 CLERICAL & GENERAL	20,712	S.I.R. MANAGEMENT, INC.	100.00%	11,937	(8,775)	23
24	V	24 EDUCATION & SEMINAR		S.I.R. MANAGEMENT, INC.	100.00%	283	283	24
25	V	25 OTHER ADMIN. STAFF TRANS.		S.I.R. MANAGEMENT, INC.	100.00%	1,985	1,985	25
26	V	26 INSURANCE		S.I.R. MANAGEMENT, INC.	100.00%	628	628	26
27	V	27 EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	3,704	3,704	27
28	V	30 DEPRECIATION		S.I.R. MANAGEMENT, INC.	100.00%	2,505	2,505	28
29	V	32 INTEREST		S.I.R. MANAGEMENT, INC.	100.00%	838	838	29
30	V	33 REAL ESTATE TAXES		S.I.R. MANAGEMENT, INC.	100.00%	3,749	3,749	30
31	V	35 EQUIPMENT RENTAL		S.I.R. MANAGEMENT, INC.	100.00%	1,529	1,529	31
32	V							32
33	V	39 LEASED EQUIPMENT		S.I.R. MANAGEMENT, INC.	100.00%			33
34	V	30 DEPRECIATION		S.I.R. MANAGEMENT, INC.	100.00%			34
35	V	32 INTEREST		S.I.R. MANAGEMENT, INC.	100.00%			35
36	V							36
37	V							37
38	V							38
39	Total		\$ 150,420			\$ 64,388	\$ * (86,032)	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Maplewood Care# 0040428Report Period Beginning: 01/01/04Ending: 12/31/04

## VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	1 DIETARY SALARIES	\$ 20,712	S.I.R. MANAGEMENT, INC.	100.00%	\$ 5,983	\$ (14,729)
16	V	7 EMP. BEN.-DIETARY		S.I.R. MANAGEMENT, INC.	100.00%	1,254	1,254
17	V	17 ADMIN./LEGAL SALARIES		S.I.R. MANAGEMENT, INC.	100.00%	43,847	43,847
18	V	19 FINANCIAL CONSULTANT		S.I.R. MANAGEMENT, INC.	100.00%	12,769	12,769
19	V	27 EMP. BEN.-ADMINISTRATIVE		S.I.R. MANAGEMENT, INC.	100.00%	6,881	6,881
20	V						
21	V	17 ADMIN. SALARY-B. BARRISH		S.I.R. MANAGEMENT, INC.	100.00%		
22	V	6 REPAIRS & MAINT.-B. BARRISH		S.I.R. MANAGEMENT, INC.	100.00%		
23	V	21 CLERICAL & GEN.-B. BARRISH		S.I.R. MANAGEMENT, INC.	100.00%		
24	V	26 AUTO INSURANCE-B. BARRISH		S.I.R. MANAGEMENT, INC.	100.00%		
25	V	27 EMP. BENEFITS-B. BARRISH		S.I.R. MANAGEMENT, INC.	100.00%		
26	V	35 AUTO LEASE-B. BARRISH		S.I.R. MANAGEMENT, INC.	100.00%		
27	V						
28	V	17 ADMIN. SALARY-M. GIANNINI		S.I.R. MANAGEMENT, INC.	100.00%		
29	V	21 CLERICAL & GEN.-M. GIANNINI		S.I.R. MANAGEMENT, INC.	100.00%		
30	V	26 AUTO INSURANCE-M. GIANNINI		S.I.R. MANAGEMENT, INC.	100.00%		
31	V	27 EMP. BENEFITS-M. GIANNINI		S.I.R. MANAGEMENT, INC.	100.00%		
32	V	35 AUTO LEASE-M. GIANNINI		S.I.R. MANAGEMENT, INC.	100.00%		
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 20,712			\$ 70,734	\$ * 50,022

\* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Maplewood Care# 0040428Report Period Beginning: 01/01/04Ending: 12/31/04

## VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	10A SPECIAL REHAB	9,012	S.I.R. MANAGEMENT, INC.	100.00%	5,323	\$ (3,689)
16	V	15 EMP. BEN.-H. CARE & PROG.		S.I.R. MANAGEMENT, INC.	100.00%	1,116	1,116
17	V						
18	V	6 REPAIRS AND MAINT.	8,618	S.I.R. MANAGEMENT, INC.	100.00%	6,299	(2,319)
19	V	7 EMP. BEN.-GEN. SERV.		S.I.R. MANAGEMENT, INC.	100.00%	1,248	1,248
20	V						
21	V						
22	V	1 DIETICIAN SALARIES	13,200	S.I.R. MANAGEMENT, INC.	100.00%	8,040	(5,160)
23	V	7 EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	1,685	1,685
24	V						
25	V	19 LEGAL FEES	16,440	S.I.R. MANAGEMENT, INC.	100.00%		(16,440)
26	V						
27	V	17 FEES	4,320	S.I.R. MANAGEMENT, INC.	100.00%		(4,320)
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 51,590			\$ 23,711	\$ * (27,879)

\* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Maplewood Care# 0040428Report Period Beginning: 01/01/04Ending: 12/31/04

## VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	22 EMPLOYEE HEALTH INSURANCE	\$	CCS EMPLOYEE BENEFIT GROUP	100.00%	\$ 98,911	\$ 98,911	15
16	V							16
17	V							17
18	V							18
19	V	22 EMPLOYEE HEALTH INSURANCE	99,448	CCS EMPLOYEE BENEFIT GROUP	100.00%		(99,448)	19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 99,448			\$ 98,911	\$ * (537)	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Maplewood Care# 0040428Report Period Beginning: 01/01/04Ending: 12/31/04

## VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	01 DIETARY	\$	XCEL MEDICAL SUPPLY, LLC	100.00%	\$	\$	15
16	V	02 FOOD		XCEL MEDICAL SUPPLY, LLC	100.00%			16
17	V	03 HOUSEKEEPING		XCEL MEDICAL SUPPLY, LLC	100.00%			17
18	V	04 LAUNDRY		XCEL MEDICAL SUPPLY, LLC	100.00%			18
19	V	06 REPAIRS & MAINTENANCE		XCEL MEDICAL SUPPLY, LLC	100.00%			19
20	V	10 NURSING	40,441	XCEL MEDICAL SUPPLY, LLC	100.00%	34,441	(6,000)	20
21	V	10A THERAPY		XCEL MEDICAL SUPPLY, LLC	100.00%			21
22	V	12 SOCIAL SERVICE		XCEL MEDICAL SUPPLY, LLC	100.00%			22
23	V	21 CLERICAL & GENERAL OFFICE		XCEL MEDICAL SUPPLY, LLC	100.00%			23
24	V	22 EMPLOYEE BENEFITS		XCEL MEDICAL SUPPLY, LLC	100.00%			24
25	V	39 ANCILLARY		XCEL MEDICAL SUPPLY, LLC	100.00%			25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 40,441			\$ 34,441	\$ * (6,000)	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Maplewood Care# 0040428Report Period Beginning: 01/01/04Ending: 12/31/04

## VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT



Facility Name & ID Number Maplewood Care# 0040428Report Period Beginning: 01/01/04Ending: 12/31/04

## VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Maplewood Care# 0040428Report Period Beginning: 01/01/04Ending: 12/31/04

## VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Maplewood Care # 0040428 Report Period Beginning: 01/01/04 Ending: 12/31/04

## VII. RELATED PARTIES (continued)

## C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

**NOTE: ALL owners ( even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.**

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Nenita Guzman	Relative	Dietary		See Attached	4.66	11.65%	Alloc. Salary	\$ 5,983	1-7	1
2	Louise Bergthold	Owner	Administrative	6.09%	See Attached	5.13	12.83%	Alloc. Salary	16,398	17-7	2
3	Tom Winter	Owner	Administrative	0.77%	See Attached	6.13	15.33%	Alloc. Salary	16,549	17-7	3
4	Jeff Oravec	Owner	Administrative	0.51%	See Attached	3.73	9.33%	Alloc. Salary	9,382	17-7	4
5	Stuart Sikes	Owner	Administrative	1.02%	See Attached	3.73	9.33%	Alloc. Salary	10,524	17-7	5
6	Joey Abramchik	Owner	Administrative	2.54%	See Attached	4.20	10.50%	Alloc. Salary	12,769	17-7	6
7	Eric Rothner	Relative	Administrative		See Attached	0.72	1.56%	Alloc. Salary	8,769	17-7	7
8	Adam Vales	Relative	Clerical		See Attached	0.64	1.60%	Alloc. Salary	667	22-7	8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 81,041		13

\* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

\*\* This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).  
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME,  
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Maplewood Care # 0040428 Report Period Beginning: 01/01/04 Ending: 12/31/04

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☒

Name of Related Organization \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City / State / Zip Code \_\_\_\_\_  
 Phone Number ( ) \_\_\_\_\_  
 Fax Number ( ) \_\_\_\_\_

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Maplewood Care# 0040428

Report Period Beginning:

01/01/04Ending: 12/31/04

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization PREFERRED BOOKKEEPING SERVICES  
 Street Address 4100 WEST PRATT AVE.  
 City / State / Zip Code LINCOLNWOOD, IL. 60712  
 Phone Number ( 847) 674-5200  
 Fax Number ( 847) 674-5267

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	3	HOUSEKEEPING	BOOK./ACCNT.INCOME	927,958	10	\$ 5,955	\$ 100,380	\$ 644	1
2	5	UTILITIES	BOOK./ACCNT.INCOME	927,958	10	7,801	100,380	844	2
3	6	REPAIRS AND MAINT.	BOOK./ACCNT.INCOME	927,958	10	5,680	100,380	614	3
4	17	ADMIN. FINANCIAL SAL.	BOOK./ACCNT.INCOME	927,958	10	152,983	100,380	16,549	4
5	19	PROFESSIONAL FEES	BOOK./ACCNT.INCOME	927,958	10	12,360	100,380	1,337	5
6	20	DUES,SUBSCRIPTIONS	BOOK./ACCNT.INCOME	927,958	10	1,874	100,380	203	6
7	21	CLERICAL	BOOK./ACCNT.INCOME	927,958	10	527,777	100,380	57,091	7
8	24	SEMINARS	BOOK./ACCNT.INCOME	927,958	10	1,493	100,380	162	8
9	25	ADMIN. STAFF TRAVEL	BOOK./ACCNT.INCOME	927,958	10	5,142	100,380	556	9
10	26	INSURANCE	BOOK./ACCNT.INCOME	927,958	10	3,729	100,380	403	10
11	27	EMPLOYEE BENEFITS	BOOK./ACCNT.INCOME	927,958	10	90,428	100,380	9,782	11
12	30	DEPRECIATION	BOOK./ACCNT.INCOME	927,958	10	18,431	100,380	1,994	12
13	32	INTEREST	BOOK./ACCNT.INCOME	927,958	10	3,338	100,380	361	13
14	33	REAL ESTATE TAXES	BOOK./ACCNT.INCOME	927,958	10	20,087	100,380	2,173	14
15	35	EQUIPMENT RENTAL	BOOK./ACCNT.INCOME	927,958	10	19,368	100,380	2,095	15
16									16
17									17
18									18
19	19	COMPUTER	DIRECT ALLOCATION					4,872	19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 876,446	\$ 619,216	\$	99,680	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Maplewood Care # 0040428 Report Period Beginning: 01/01/04 Ending: 12/31/04

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization S.I.R. MANAGEMENT, INC.  
 Street Address 6840 N. LINCOLN  
 City / State / Zip Code LINCOLNWOOD, IL. 60712  
 Phone Number ( 847) 675 -7979  
 Fax Number ( 847) 675 -0555

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5 UTILITIES	PATIENT DAYS	678,909	11	\$ 13,981	\$	63,291	\$ 1,303	1
2	6 REPAIRS AND MAINT.	PATIENT DAYS	678,909	11	63,606		63,291	5,930	2
3	7 EMP. BEN.-GEN. SERV.	PATIENT DAYS	678,909	11	9,483		63,291	884	3
4	10 NURSING	PATIENT DAYS	678,909	11	178,013	178,013	63,291	16,595	4
5	15 EMP. BEN.-H.C.	PATIENT DAYS	678,909	11	33,716		63,291	3,143	5
6	17 ADMINISTRATIVE	PATIENT DAYS	678,909	11	95,266	95,266	63,291	8,881	6
7	19 PROFESSIONAL FEES	PATIENT DAYS	678,909	11	3,242		63,291	302	7
8	20 FEES,SUBSCRIPTIONS	PATIENT DAYS	678,909	11	2,062		63,291	192	8
9	21 CLERICAL & GENERAL	PATIENT DAYS	678,909	11	128,049	90,910	63,291	11,937	9
10	24 EDUCATION & SEMINAR	PATIENT DAYS	678,909	11	3,040		63,291	283	10
11	25 OTHER ADMIN. STAFF TRANS	PATIENT DAYS	678,909	11	21,297		63,291	1,985	11
12	26 INSURANCE	PATIENT DAYS	678,909	11	6,736		63,291	628	12
13	27 EMP. BEN.-GEN. ADMIN.	PATIENT DAYS	678,909	11	39,734		63,291	3,704	13
14	30 DEPRECIATION	PATIENT DAYS	678,909	11	26,873		63,291	2,505	14
15	32 INTEREST	PATIENT DAYS	678,909	11	8,988		63,291	838	15
16	33 REAL ESTATE TAXES	PATIENT DAYS	678,909	11	40,220		63,291	3,749	16
17	35 EQUIPMENT RENTAL	PATIENT DAYS	678,909	11	16,401		63,291	1,529	17
18									18
19	39 LEASED EQUIPMENT	LEASING INCOME	52,560	1					19
20	30 DEPRECIATION	LEASING INCOME	52,560	1	24,293				20
21	32 INTEREST	LEASING INCOME	52,560	1	6,298				21
22									22
23									23
24									24
25	TOTALS				\$ 721,298	\$ 410,443		\$ 64,388	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Maplewood Care# 0040428

Report Period Beginning:

01/01/04Ending: 12/31/04

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization S.I.R. MANAGEMENT, INC.Street Address 6840 N. LINCOLNCity / State / Zip Code LINCOLNWOOD, IL. 60712Phone Number ( 847) 675 -7979Fax Number ( 847) 675 -0555

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	DIETARY SALARIES	PATIENT DAYS	678,909	11	\$ 64,183	\$ 64,183	63,291	\$ 5,983	1
2	EMP. BEN.-DIETARY	PATIENT DAYS	678,909	11	13,453		63,291	1,254	2
3	ADMIN./LEGAL SALARIES	PATIENT DAYS	678,909	11	470,339	470,339	63,291	43,847	3
4	FINANCIAL CONSULTANT	PATIENT DAYS	678,909	11	136,972		63,291	12,769	4
5	EMP. BEN.-ADMINISTRATIVE	PATIENT DAYS	678,909	11	73,815		63,291	6,881	5
6									6
7	17 ADMIN. SALARY-B. BARRISH	AVG HRS WKD	30	4	155,406	155,406			7
8	6 REPAIRS & MAINT.-B. BARRISH	AVG HRS WKD	30	4	1,462				8
9	21 CLERICAL & GEN.-B. BARRISH	AVG HRS WKD	30	4	1,426				9
10	26 AUTO INSURANCE-B. BARRISH	AVG HRS WKD	30	4	733				10
11	27 EMP. BENEFITS-B. BARRISH	AVG HRS WKD	30	4	32,115				11
12	35 AUTO LEASE-B. BARRISH	AVG HRS WKD	30	4	16,634				12
13									13
14	17 ADMIN. SALARY-M. GIANNINI	AVG HRS WKD	30	4	150,673	150,673			14
15	21 CLERICAL & GEN.-M. GIANNINI	AVG HRS WKD	30	4	560				15
16	26 AUTO INSURANCE-M. GIANNINI	AVG HRS WKD	30	4	726				16
17	27 EMP. BENEFITS-M. GIANNINI	AVG HRS WKD	30	4	31,946				17
18	35 AUTO LEASE-M. GIANNINI	AVG HRS WKD	30	4	6,756				18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 1,157,199	\$ 840,601		\$ 70,734	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Maplewood Care # 0040428 Report Period Beginning: 01/01/04 Ending: 12/31/04

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization S.I.R. MANAGEMENT, INC.  
 Street Address 6840 N. LINCOLN  
 City / State / Zip Code LINCOLNWOOD, IL. 60712  
 Phone Number ( 847) 675 -7979  
 Fax Number ( 847) 675 -0555

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10A SPECIAL REHAB	SPECIAL REHAB INC.	107,736	7	\$ 63,630	\$ 63,630	9,012	\$ 5,323	1
2	15 EMP. BEN.-H. CARE & PROG.	SPECIAL REHAB INC.	107,736	7	13,337		9,012	1,116	2
3									3
4	6 REPAIRS AND MAINT.	MAINTENANCE INC.	143,028	11	107,866	107,866	8,352	6,299	4
5	7 EMP. BEN.-GEN. SERV.	MAINTENANCE INC.	143,028	11	21,371		8,352	1,248	5
6									6
7									7
8	1 DIETICIAN SALARIES	DIETICIAN SERVICE INC.	125,400	10	76,377	76,377	13,200	8,040	8
9	7 EMP. BEN.-GEN. ADMIN.	DIETICIAN SERVICE INC.	125,400	10	16,008		13,200	1,685	9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 298,589	\$ 247,873		\$ 23,711	25

SEE ACCOUNTANTS' COMPILATION REPORT



Facility Name & ID Number Maplewood Care # 0040428 Report Period Beginning: 01/01/04 Ending: 12/31/04

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization CCS EMPLOYEE BENEFITS GROUP, INC.  
 Street Address 4101 W. MAIN ST.  
 City / State / Zip Code SKOKIE, IL 60076  
 Phone Number ( 847)905-4000  
 Fax Number ( 847)905-4040

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	22	EMPLOYEE HEALTH INSURANCE	DIRECT ALLOCATION		\$	\$		\$ 98,911	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$ 98,911	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Maplewood Care # 0040428 Report Period Beginning: 01/01/04 Ending: 12/31/04

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization XCEL MEDICAL SUPPLY, LLC  
 Street Address 2201 MAIN STREET  
 City / State / Zip Code EVANSTON, IL 60202  
 Phone Number ( 847)328-7600  
 Fax Number ( 847)328-7615

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	01	DIETARY	Direct Allocation		\$	\$		\$	1
2	02	FOOD	Direct Allocation						2
3	03	HOUSEKEEPING	Direct Allocation						3
4	04	LAUNDRY	Direct Allocation						4
5	06	REPAIRS & MAINTENANCE	Direct Allocation						5
6	10	NURSING	Direct Allocation					34,441	6
7	10A	THERAPY	Direct Allocation						7
8	12	SOCIAL SERVICE	Direct Allocation						8
9	21	CLERICAL & GENERAL OFFICE	Direct Allocation						9
10	22	EMPLOYEE BENEFITS	Direct Allocation						10
11	39	ANCILLARY	Direct Allocation						11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$ 34,441	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Maplewood Care # 0040428 Report Period Beginning: 01/01/04 Ending: 12/31/04

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City / State / Zip Code \_\_\_\_\_  
 Phone Number ( ) \_\_\_\_\_  
 Fax Number ( ) \_\_\_\_\_

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Maplewood Care # 0040428 Report Period Beginning: 01/01/04 Ending: 12/31/04

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City / State / Zip Code \_\_\_\_\_  
 Phone Number ( ) \_\_\_\_\_  
 Fax Number ( ) \_\_\_\_\_

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Maplewood Care # 0040428 Report Period Beginning: 01/01/04 Ending: 12/31/04

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City / State / Zip Code \_\_\_\_\_  
 Phone Number ( ) \_\_\_\_\_  
 Fax Number ( ) \_\_\_\_\_

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related Long-Term												
1	CIB Bank		X	Facility Improvement			\$ 600,000	\$			\$ 508	1	
2												2	
3												3	
4												4	
5	See Supplemental Schedule										516,000	5	
	Working Capital												
6	CIB Bank		X	Working Capital		06/20/03		2,505,000			123,828	6	
7												7	
8	See Supplemental Schedule											8	
9	TOTAL Facility Related						\$ 600,000	\$ 2,505,000			\$ 640,336	9	
	B. Non-Facility Related*												
10	Allocation Preferred		X								361	10	
11	Allocation SIR		X								838	11	
12												12	
13	See Supplemental Schedule											13	
14	TOTAL Non-Facility Related						\$	\$			\$ 1,199	14	
15	TOTALS (line 9+line14)						\$ 600,000	\$ 2,505,000			\$ 641,535	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ None Line # N/A

\* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.  
(See instructions.) SEE ACCOUNTANTS' COMPILATION REPORT

\*\* If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.  
(See instructions.)

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE - SUPPLEMENTAL SCHEDULE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	Alloc. Maplewood-Jane, LLC		X				\$	\$			\$	516,000	1
2													2
3													3
4													4
5													5
6													6
7	TOTAL Long-Term											516,000	7
	Working Capital												
8							\$	\$			\$		8
9													9
10													10
11													11
12													12
13													13
14	TOTAL Working Capital												14
	B. Non-Facility Related*												
15							\$	\$			\$		15
16													16
17													17
18													18
19													19
20	TOTAL Non-Facility Related												20

\* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.  
(See instructions.) SEE ACCOUNTANTS' COMPILATION REPORT

\*\* If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.  
(See instructions.)

Facility Name & ID Number **Maplewood Care**# **0040428** Report Period Beginning: **01/01/04** Ending: **12/31/04****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

		<b>Important</b> , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2003 report.		\$	<b>119,360</b>	1	
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	<b>119,286</b>	2	
3. Under or (over) accrual (line 2 minus line 1).		\$	<b>(74)</b>	3	
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<b>103,800</b>	4	
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$	<b>2,625</b>	5	
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$      For      Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$		6	
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<b>106,351</b>	7	
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	1999	<b>85,194</b>	8		
	2000	<b>87,263</b>	9		
	2001	<b>89,959</b>	10		
	2002	<b>97,223</b>	11		
	2003	<b>101,520</b>	12		
<b>\$101,524 x 1.002 = \$101,760</b>					
<b>Beginning accrual adjusted by \$18,260 for transfer of net escrow</b>				13	FROM R. E. TAX STATEMENT FOR 2003 \$ 13
<b>Allocation Preferred Bookkeeping - \$2,173</b>				14	PLUS APPEAL COST FROM LINE 5 \$ 14
<b>Allocation SIR Management - \$3,749</b>				15	LESS REFUND FROM LINE 6 \$ 15
				16	AMOUNT TO USE FOR RATE CALCULATION \$ 16

**NOTES:**

1. Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.  
**This denial must be no more than four years old at the time the cost report is filed.**

SEE ACCOUNTANTS' COMPILATION REPORT



**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates    **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed.** If you have any questions, please call the Office of Health Finance at (217) 782-1630.

FACILITY NAME Maplewood Care COUNTY Kane  
FACILITY IDPH LICENSE NUMBER 0040428  
CONTACT PERSON REGARDING THIS REPORT Steve Lavenda  
TELEPHONE (847)236-1111 FAX #: (847)236-1155

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

## B. Real Estate Tax Cost Allocations

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates    **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed.** If you have any questions, please call the Office of Health Finance at (217) 782-1630.

FACILITY NAME Maplewood Care COUNTY Kane  
FACILITY IDPH LICENSE NUMBER 0040428  
CONTACT PERSON REGARDING THIS REPORT Steve Lavenda  
TELEPHONE (847)236-1111 FAX #: (847)236-1155

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

## B. Real Estate Tax Cost Allocations

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

A. Square Feet:
 

36,780

B. General Construction Type:
 

Exterior
 

Brick

Frame

Number of Stories

C. Does the Operating Entity?
 

☐ (a) Own the Facility
 ☒ (b) Rent from a Related Organization.
 ☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?
 

☒ (a) Own the Equipment
 ☒ (b) Rent equipment from a Related Organization.
 ☒ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?
 

☐ YES
 ☒ NO

If so, please complete the following:

1. Total Amount Incurred:
 

16,587

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:
 

16,587

4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1			1993	\$ 262,479	1
2					2
3	TOTALS			\$ 262,479	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number    Maplewood Care

#    0040428

Report Period Beginning:

01/01/04

Ending:

12/31/04

**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9	Various		1993		98,204		20	3,593	3,593	44,166	9
10	Various		1994		13,684		20	684	684	7,786	10
11	Various		1995		5,179		20	259	259	2,451	11
12	Various		1996		19,800		20	990	(990)	8,745	12
13	Various		1997		21,688		20	1,085	1,085	8,514	13
14	Various		1998		19,077		20	955	955	5,998	14
15	Various		1999		47,028		20	2,195	2,195	11,807	15
16	Various		2000		565,082		20	28,254	28,254	136,145	16
17								-		-	17
18								-		-	18
19								-		-	19
20								-		-	20
21								-		-	21
22								-		-	22
23								-		-	23
24								-		-	24
25								-		-	25
26								-		-	26
27								-		-	27
28								-		-	28
29								-		-	29
30								-		-	30
31								-		-	31
32								-		-	32
33								-		-	33
34								-		-	34
35								-		-	35
36								-		-	36

\*Total beds on this schedule must agree with page 2.

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$	\$		37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12-BLDG & 12A-BLDG)		5,445,306	15,921			(15,921)	2,064,884	67
68	Related Party Allocations (Pages 12-REP & 12A-REP)		79,946	2,715		3,149	434	29,978	68
69	Financial Statement Depreciation			76,646			(76,646)		69
70	TOTAL (lines 4 thru 69)		\$ 6,314,994	\$ 95,282		\$ 41,164	\$ (56,098)	\$ 2,320,474	70

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)
 B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12A, Carried Forward		\$ 6,314,994	\$ 95,282		\$ 41,164	\$ (54,118)	\$ 2,320,474		1
2	Water Heater	2001	10,761		20	538	538	2,107		2
3	Elevator Work	2001	13,900		20	695	695	2,664		3
4	Flooring	2001	14,489		20	1,449	1,449	5,313		4
5	Flooring	2001			20					5
6	Hvac Work	2001	9,400		20	470	470	1,684		6
7	Electrical Work	2001	13,800		20	690	690	2,358		7
8	Condensing Unit	2001	1,840		20	92	92	307		8
9	Heat Exchanger	2001	1,633		20	82	82	313		9
10	Hot Water Heater	2001	1,142		20	57	57	214		10
11	Drain Work	2001	2,400		20	120	120	440		11
12	Painting	2001	690		20	35	35	124		12
13	Painting	2001	522		20	26	26	87		13
14	Ductwork	2001	1,084		20	54	54	195		14
15	Hvac	2001	1,187		20	59	59	193		15
16	Outlets	2002	4,351		20	435	435	1,305		16
17	Water Meter Work	2002	1,626		20	163	163	488		17
18	Compressor	2002	2,401		20	240	240	620		18
19	Hvac	2002	1,727		20	173	173	403		19
20	Roofing	2002	1,099		20	55	55	147		20
21	Cooling System	2002	1,560		20	78	78	208		21
22	Heating System	2002	1,033		20	52	52	138		22
23	Cubicle Curtains	2002	1,727		20	86	86	230		23
24	Stair Rails	2003	2,000		20	100	100	200		24
25	Heat Exchange	2003	2,276		20	114	114	228		25
26	Walk-In Cooler Work	2003	2,673		20	134	134	234		26
27	Sprinkler System	2003	6,975		20	349	349	610		27
28	Sealcoating Parking Lot	2003	3,300		20	165	165	220		28
29	Vinyl Tile	2003	930		20	47	47	62		29
30	Hvac Register	2003	1,000		20	50	50	63		30
31	Furnace Ignitor, Flame Sensor	2003	1,116		20	56	56	65		31
32	Hvac Ignition, High Limit Control	2003	1,026		20	51	51	60		32
33	Hvac Fan Delay Timer, Etc	2003	1,053		20	53	53	57		33
34	TOTAL (lines 1 thru 33)		\$ 6,425,715	\$ 95,282		\$ 47,932	\$ (47,350)	\$ 2,341,811		34

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

SEE ACCOUNTANTS' COMPILATION REPORT

## XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 6,425,715	\$ 95,282		\$ 47,932	\$ (47,350)	\$ 2,341,811	1
2	Elevator Work	2004	1,334		20	67	67	67	2
3	Plumbing	2004	4,952		20	62	62	62	3
4	Steel Door	2004	3,900		20	65	65	65	4
5	Blinds	2004	423		20	21	21	21	5
6	Verticle Rod Panel Bar	2004	584		20	29	29	29	6
7	Vinyl Blinds	2004	628		20	31	31	31	7
8	Tile Repair	2004	801		20	80	80	80	8
9	Compressor	2004	1,558		20	78	78	78	9
10	Condesor Fan Motors	2004	2,119		20	106	106	106	10
11	Fire Sprinkler Repair	2004	1,789		20	89	89	89	11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 6,443,803	\$ 95,282		\$ 48,561	\$ (46,721)	\$ 2,342,439	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 6,443,803	\$ 95,282		\$ 48,561	\$ (46,721)	\$ 2,342,439	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 6,443,803	\$ 95,282		\$ 48,561	\$ (46,721)	\$ 2,342,439	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.



XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 6,443,803	\$ 95,282		\$ 48,561	\$ (46,721)	\$ 2,342,439	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 6,443,803	\$ 95,282		\$ 48,561	\$ (46,721)	\$ 2,342,439	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		\$ 6,443,803	\$ 95,282		\$ 48,561	\$ (46,721)	\$ 2,342,439	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 6,443,803	\$ 95,282		\$ 48,561	\$ (46,721)	\$ 2,342,439	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		\$ 6,443,803	\$ 95,282		\$ 48,561	\$ (46,721)	\$ 2,342,439	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 6,443,803	\$ 95,282		\$ 48,561	\$ (46,721)	\$ 2,342,439	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)								
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.								
1	2	3	4	5	6	7	8	9
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
1	Totals from Page 12G, Carried Forward		\$ 6,443,803	\$ 95,282		\$ 48,561	\$ (46,721)	\$ 2,342,439
2								
3								
4								
5								
6								
7								
8								
9								
10								
11								
12								
13								
14								
15								
16								
17								
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19								
20								
21								
22								
23								
24								
25								
26								
27								
28								
29								
30								
31								
32								
33								
34	TOTAL (lines 1 thru 33)		\$ 6,443,803	\$ 95,282		\$ 48,561	\$ (46,721)	\$ 2,342,439

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		\$ 6,443,803	\$ 95,282		\$ 48,561	\$ (46,721)	\$ 2,342,439	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 6,443,803	\$ 95,282		\$ 48,561	\$ (46,721)	\$ 2,342,439	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		\$ 6,443,803	\$ 95,282		\$ 48,561	\$ (46,721)	\$ 2,342,439	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 6,443,803	\$ 95,282		\$ 48,561	\$ (46,721)	\$ 2,342,439	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)								
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.								
1	2	3	4	5	6	7	8	9
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
1	Totals from Page 12J, Carried Forward		\$ 6,443,803	\$ 95,282		\$ 48,561	\$ (46,721)	\$ 2,342,439
2								
3								
4								
5								
6								
7								
8								
9								
10								
11								
12								
13								
14								
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21								
22								
23								
24								
25								
26								
27								
28								
29								
30								
31								
32								
33								
34	TOTAL (lines 1 thru 33)		\$ 6,443,803	\$ 95,282		\$ 48,561	\$ (46,721)	\$ 2,342,439

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)										
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.										
	1 Beds*	2 FOR OHF USE ONLY	3 Year Acquired	4 Year Constructed	5 Cost	6 Current Book Depreciation	7 Life in Years	8 Straight Line Depreciation	9 Adjustments	10 Accumulated Depreciation
4	203		1993		\$ 5,445,306	\$ 15,921	35	\$	(15,921)	\$ 2,064,884
5										
6										
7										
8										
9	Improvement Type**									
10										
11										
12										
13										
14										
15										
16										
17										
18										
19										
20										
21										
22										
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24										
25										
26										
27										
28										
29										
30										
31										
32										
33										
34										
35										
36										

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.



XI. OWNERSHIP COSTS (continued)
 B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37			\$	\$		\$	\$		37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
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54									54
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56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 5,445,306	\$ 15,921		\$	\$ (15,921)	\$ 2,064,884	70

## XI. OWNERSHIP COSTS (continued)

## B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	Alloc SIR Properties - SIR Management		1993	\$ 24,910	\$ 791	35	\$ 712	\$ (79)	\$ 8,185
5	Aloc SIR Properties - Preferred Bookkeeping		1993	14,436	458	35	412	(46)	4,743
6									
7									
8									
9	Improvement Type**								
10	Prefered Bookkeeping Allocation		1997	18,029	404	20	901	497	7,039
11	Prefered Bookkeeping Allocation		1999	143	-	20	7	7	39
12	Prefered Bookkeeping Allocation		2000	904	-	20	45	(45)	200
13									
14	SIR Management		1993	10,699	298	20	530	232	6,366
15	SIR Management		1994	33	-	20	2	2	33
16	SIR Management		1995	245	-	20	12	12	115
17	SIR Management		1999	1,162	-	20	58	58	303
18	SIR Management		2000	702	-	20	35	35	165
19									
20	SIR Properties - Preferred Bookkeeping		2002	57	-	20	3	3	7
21	SIR Properties - Preferred Bookkeeping		1999	1,829	183	20	91	(92)	503
22	SIR Properties - Preferred Bookkeeping		1998	874	87	20	44	(43)	284
23	SIR Properties - Preferred Bookkeeping		1997	54	5	20	3	(2)	23
24	SIR Properties - Preferred Bookkeeping		1994	137	4	20	7	3	72
25	SIR Properties - Preferred Bookkeeping		1993	234	1	20	12	11	135
26									
27	SIR Properties - SIR Management		2002	99	-	20	5	5	12
28	SIR Properties - SIR Management		1999	3,156	316	20	158	(158)	868
29	SIR Properties - SIR Management		1998	1,508	151	20	75	(76)	490
30	SIR Properties - SIR Management		1997	94	9	20	5	(4)	40
31	SIR Properties - SIR Management		1994	237	6	20	12	6	124
32			1993	404	2	20	20	18	232
33									
34									
35									
36									

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)
 B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37			\$	\$		\$	\$		37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 79,946	\$ 2,715		\$ 3,149	\$ 344	\$ 29,978	70

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 81,324	\$ 1,674	\$ 4,812	\$ 3,138	10	\$ 55,908	71
72	Current Year Purchases	8,535	110	381	271	10	381	72
73	Fully Depreciated Assets	37				10	37	73
74								74
75	TOTALS	\$ 89,896	\$ 1,784	\$ 5,193	\$ 3,409		\$ 56,326	75

D. Vehicle Depreciation (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 6,796,178	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 97,066	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 53,754	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (43,312)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,398,765	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

\* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

\*\* This must agree with Schedule V line 30, column 8.

SEE ACCOUNTANTS' COMPILATION REPORT

## XII. RENTAL COSTS

### A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

\*\*

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized  
by the length of the lease                     .

9. Option to Buy: ☐ YES ☒ NO Terms:                                     \*

### B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

☐ YES ☐ NO

16. Rental Amount for movable equipment: \$ 8,952

Description: See Attached Schedule

(Attach a schedule detailing the breakdown of movable equipment)

### C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Facility	2001 Chevy Express Van	\$ 339.97	\$ 3,690	17
18					18
19					19
20					20
21	TOTAL		\$ 339.97	\$ 3,690	21

10. Effective dates of current rental agreement:

Beginning                     

Ending                     

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12.                      /2005 \$                     

13.                      /2006 \$                     

14.                      /2007 \$                     

\* If there is an option to buy the building, please provide complete details on attached schedule.

\*\* This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

<p>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		1 Facility		2	3	4
		Drop-outs	Completed	Contract	Total	
1	Community College Tuition	\$	\$	\$	\$	
2	Books and Supplies					
3	Classroom Wages (a)					
4	Clinical Wages (b)					
5	In-House Trainer Wages (c)					
6	Transportation					
7	Contractual Payments					
8	Nurse Aide Competency Tests					
9	TOTALS	\$	\$	\$	\$	
10	SUM OF line 9, col. 1 and 2 (e)	\$				

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.  
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.  
(c) For in-house training programs only. Do not include fringe benefits.  
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.  
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.  
SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$ 23,656	\$		\$ 23,656	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			266			266	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			9,719			9,719	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				30,140		30,140	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program	39 - 02					4,459		4,459	12
13	Other (specify): See Supplemental					99	13,659		13,758	13
14	TOTAL			\$		\$ 33,740	\$ 48,258		\$ 81,998	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 45,347	\$ 45,348	1
2	Cash-Patient Deposits	41,332	41,332	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	875,102	875,102	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	23,323	23,323	6
7	Other Prepaid Expenses	3,557	48,203	7
8	Accounts Receivable (owners or related parties)	20,300	20,300	8
9	Other(specify): <a href="#">See Attached Schedule</a>		22,340	9
10	<b>TOTAL Current Assets</b> (sum of lines 1 thru 9)	\$ 1,008,961	\$ 1,075,948	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		517,253	13
14	Buildings, at Historical Cost		2,518,622	14
15	Leasehold Improvements, at Historical Cost	582,981	582,981	15
16	Equipment, at Historical Cost	745,019	1,354,019	16
17	Accumulated Depreciation (book methods)	(784,448)	(3,458,332)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		29,997	19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <a href="#">See Attached Schedule</a>	647,463	647,463	23
24	<b>TOTAL Long-Term Assets</b> (sum of lines 11 thru 23)	\$ 1,191,015	\$ 2,192,003	24
25	<b>TOTAL ASSETS</b> (sum of lines 10 and 24)	\$ 2,199,976	\$ 3,267,951	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 117,200	\$ 117,200	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	40,649	40,649	28
29	Short-Term Notes Payable	2,505,000	2,505,000	29
30	Accrued Salaries Payable	152,658	152,658	30
31	Accrued Taxes Payable (excluding real estate taxes)	14,966	14,966	31
32	Accrued Real Estate Taxes(Sch.IX-B)		103,800	32
33	Accrued Interest Payable	4,404	(87,552)	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<a href="#">See Attached Schedule</a>	6,087	4,258,462	36
37				37
38	<b>TOTAL Current Liabilities</b> (sum of lines 26 thru 37)	\$ 2,840,964	\$ 7,105,183	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43	<a href="#">See Attached Schedule</a>			43
44				44
45	<b>TOTAL Long-Term Liabilities</b> (sum of lines 39 thru 44)	\$	\$	45
46	<b>TOTAL LIABILITIES</b> (sum of lines 38 and 45)	\$ 2,840,964	\$ 7,105,183	46
47	<b>TOTAL EQUITY</b> (page 18, line 24)	\$ (640,988)	\$ (3,837,232)	47
48	<b>TOTAL LIABILITIES AND EQUITY</b> (sum of lines 46 and 47)	\$ 2,199,976	\$ 3,267,951	48

SEE ACCOUNTANTS' COMPILATION REPORT

\*(See instructions.)



**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	<b>\$ (495,347)</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	<b>\$ (495,347)</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>(293,391)</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	<b>( )</b>	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe) <b>Capital Contributions</b>	<b>147,750</b>	<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	<b>\$ (145,641)</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	<b>\$</b>	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	<b>\$ (640,988)</b>	<b>24 *</b>

\* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

## STATE OF ILLINOIS

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Facility Name &amp; ID Number Maplewood Care

# 0040428

Report Period Beginning: 01/01/04

Ending:

12/31/04

**VII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

**Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.**

	Revenue	Amount	
	<b>A. Inpatient Care</b>		
1	Gross Revenue -- All Levels of Care	\$ 5,726,081	1
2	Discounts and Allowances for all Levels	12,061	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 5,738,142	3
	<b>B. Ancillary Revenue</b>		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	102,380	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 102,380	8
	<b>C. Other Operating Revenue</b>		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	28,830	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	4,174	19
20	Radiology and X-Ray	2,711	20
21	Other Medical Services	18,144	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 53,859	23
	<b>D. Non-Operating Revenue</b>		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$	26
	<b>E. Other Revenue (specify):****</b>		
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<a href="#">See Supplemental Schedule</a>		28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 5,894,381	30

	Expenses	Amount	
	<b>A. Operating Expenses</b>		
31	General Services	1,189,841	31
32	Health Care	2,694,305	32
33	General Administration	1,298,220	33
	<b>B. Capital Expense</b>		
34	Ownership	811,960	34
	<b>C. Ancillary Expense</b>		
35	Special Cost Centers	81,998	35
36	Provider Participation Fee	111,448	36
	<b>D. Other Expenses (specify):</b>		
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 6,187,772	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(293,391)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (293,391)	43

\* This must agree with page 4, line 45, column 4.

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? Cash Basis If not, please attach a reconciliation.

\*\*\* See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT

\*\*\*\*Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Maplewood Care# 0040428Report Period Beginning: 01/01/04Ending: 12/31/04

## XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,817	2,170	\$ 68,452	\$ 31.54	1
2	Assistant Director of Nursing	3,091	3,509	88,801	25.31	2
3	Registered Nurses	23,682	25,146	611,491	24.32	3
4	Licensed Practical Nurses	2,511	2,656	60,839	22.91	4
5	Nurse Aides & Orderlies	71,681	73,800	799,905	10.84	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	9,842	10,369	103,443	9.98	8
9	Activity Director	1,874	2,091	29,068	13.90	9
10	Activity Assistants	8,093	8,408	63,651	7.57	10
11	Social Service Workers			156,466		11
12	Dietician					12
13	Food Service Supervisor	1,826	2,091	43,215	20.67	13
14	Head Cook	1,566	1,712	12,861	7.51	14
15	Cook Helpers/Assistants	22,079	23,556	169,642	7.20	15
16	Dishwashers					16
17	Maintenance Workers	3,137	3,784	60,726	16.05	17
18	Housekeepers	26,539	28,258	194,944	6.90	18
19	Laundry	6,974	7,459	52,806	7.08	19
20	Administrator	1,906	2,091	56,916	27.22	20
21	Assistant Administrator	1,098	1,098	500	0.46	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	15,387	15,272	181,799	11.90	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	4,174	4,551	84,399	18.55	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>	3,536	3,536	9,723	2.75	33
34	TOTAL (lines 1 - 33)	210,813	221,557	\$ 2,849,647 *	\$ 12.86	34

\* This total must agree with page 4, column 1, line 45.

\*\* See instructions.

## B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	\$ 13,200	01-03	35
36	Medical Director	Monthly	6,000	09-03	36
37	Medical Records Consultant	96	4,128	10-03	37
38	Nurse Consultant	Monthly	40,200	10-03	38
39	Pharmacist Consultant	51	3,075	10-03	39
40	Physical Therapy Consultant	Monthly	12,442	10a-03	40
41	Occupational Therapy Consultant	Monthly	1,886	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	82	2,856	11-03	44
45	Social Service Consultant	86	4,716	12-03	45
46	Other(specify)				46
47	<u>Dir of Food Service</u>	Monthly	20,712	01-03	47
48	<u>Psycho Social</u>	150	7,200	12-03	48
49	TOTAL (lines 35 - 48)	465	\$ 116,415		49

## C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	9,531	\$ 428,903	10-03	50
51	Licensed Practical Nurses				51
52	Nurse Aides	98	2,448	10-03	52
53	TOTAL (lines 50 - 52)	9,629	\$ 431,351		53

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Maplewood Care# 0040428Report Period Beginning: 01/01/04Ending: 12/31/04

## XIX. SUPPORT SCHEDULES

A. Administrative Salaries			D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Jamie Lloyd	Administrator	0	\$ 57,416	Workers' Compensation Insurance	\$ 40,223	IDPH License Fee	\$	
				Unemployment Compensation Insurance	29,252	Advertising: Employee Recruitment	19,578	
				FICA Taxes	212,236	Health Care Worker Background Check		
				Employee Health Insurance	46,527	(Indicate # of checks performed <u>19</u> )	736	
				Employee Meals	31,128	Due & Subscriptions	6,232	
				Illinois Municipal Retirement Fund (IMRF)*		Licenses & Permits	8,970	
				Employee Benefits	4,235	Advertising & Promotion	6,853	
				401K Contributions	3,688	Allocation Preferred Bookkeeping	203	
						Allocation SIR Management	192	
						Less: Public Relations Expense	( )	
						Non-allowable advertising	(6,853)	
						Yellow page advertising	( )	
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 57,416	TOTAL (agree to Schedule V,	\$ 367,290	TOTAL (agree to Sch. V,	\$ 35,911	
(List each licensed administrator separately.)				line 22, col.8)		line 20, col. 8)		
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description		Amount	Description	Line #	Amount	Description	Amount	
Ancillary Administrative-SIR Management		\$ 45,648			\$	Out-of-State Travel	\$	
Director of Administrative Services - SIR Management		25,584						
SIR Management Fes		4,320				In-State Travel		
TOTAL (agree to Schedule V, line 17, col. 3)		\$ 75,552				Seminar Expense	4,503	
(Attach a copy of any management service agreement)						Allocation Preferred Bookkeeping	162	
C. Professional Services						Allocation SIR Management	283	
Vendor/Payee	Type	Amount				Entertainment Expense	( )	
Preferred Bookkeeping	Bookkeeping Services	\$ 73,080				(agree to Sch. V,		
Preferred Bookkeeping	Computer Services	4,872				line 24, col. 8)	\$ 4,948	
SIR Management	Director of Reg Services	16,440						
SIR Management	Personnel Planners	1,117						
Preferred Bookkeeping	Accounting	27,300						
SAS Architects	Architect	640						
LTC Solutions	Software Support	1,320						
ICS Solutions	Website	209						
PVS Service	Valuation Services	2,500						
FR&R	Accounting	13,980						
See Supplemental Schedule		28,941						
TOTAL (agree to Schedule V, line 19, column 3)			TOTAL		\$			
(If total legal fees exceed \$2500 attach copy of invoices.)		\$ 170,399						

\* Attach copy of IMRF notifications  
SEE ACCOUNTANTS' COMPILATION REPORT

\*\*See instructions.

**XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS** (which have been included in Sch. V, line 6, col. 3).  
(See instructions.)

1		2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Maplewood Care

STATE OF ILLINOIS

# 0040428

Report Period Beginning:

01/01/04

Ending:

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12/31/04

**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN, LPN, NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes  
If YES, give association name and amount. IL Council on LTC - \$9,373
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? \_\_\_\_\_
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 10 Yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 2,381 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? X YES \_\_\_\_\_ NO \_\_\_\_\_
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES \_\_\_\_\_ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.  
\_\_\_\_\_
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 111,448  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

**SEE ACCOUNTANTS' COMPILATION REPORT**

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? N/A For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 31,128 Has any meal income been offset against related costs? N/A Indicate the amount. \$ N/A
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A  
c. What percent of all travel expense relates to transportation of nurses and patients? 100% In 14  
d. Have vehicle usage logs been maintained? N/A  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A  
**g. Does the facility transport residents to and from day training? No**  
**Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A**
- (17) Has an audit been performed by an independent certified public accounting firm? No  
Firm Name: N/A The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? \_\_\_\_\_ If no, please explain. N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? Yes  
Attach invoices and a summary of services for all architect and appraisal fees.